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PATIENT REGISTRATION FORM:

Name:_____ SSN:_____
FIRST MIDDLE INI LAST

Address:_____
STREET ADDRESS CITY STATE ZIP CODE

Date of Birth:_____ Age:_____ Sex: M:____ F:____ Marital Status: S:___ M:___ D:___ W:___

Home:_(_____)_____ Work:__(_____)_____ Cell:__(_____)_____

Email:_____

Emergency Contact:_____ Relationship:_____ Phone#:_____

Primary Care Doctor:_____ Provider Phone: _____

Are you Employed? No___ Yes___ If yes Occupation?_____

Employer address:_____ Phone:_____

Have you missed any time off work? No:___ Yes:___ What dates?_____

PERSONAL INJURY INFORMATION:

Date of Accident:_____ **Time**:_____ am/pm **Location:** MD___ VA___ DC___ Other _____

- **You were in the:** Driver:__ Front passenger:__ Right back passenger seat:__ Left back passenger seat:___
- **How many people were in the car? _____ Were you wearing a seatbelt?** □Yes □No
- **Year/Make/Model of your car?** _____
- **At fault driver's Year/Make/Model of car?** _____
- **You were:** Stopped:___ Slowing down:___ Accelerating:___
- **Estimated speed of your car?** _____MPH **Road conditions:** Dry:___ Wet:___ Snow:___ Ice:___
- **Did the air bag deploy?** Yes:___ No:___ **Were you aware of impending collision?** Yes:___ No:___
- **What position was your body in at time of impact?** Sitting upright:___ Leaned fwd:___ Leaned bkwrds:___
- **Did your body hit anything in the car?** No:___ Don't know:___ If yes, what?_____
- **Did you lose consciousness?** No:___ Yes:___ Length of time:_____ _____
- **Estimated damage to your car:** None___ Minor:___ Moderate:___ Totaled:___

How did the accident happened?_____
_____
_____
_____

PATIENT'S HISTORY OF SYMPTOM'S:

Mark all areas of pain:

□ Head □ Neck □ Upper back □ Mid back □ Low back □ R/L Shoulder □ R/L Wrist □ R/L Hip
□ R/L Knee □ R/L Ankle
Other:_____

When did your symptoms first appear?_____

Check all activities that make your pain worse:

□turning head □sitting □standing □bending □lifting □walking □pushing □pulling □overhead reaching
□Other:_____

Since the accident, is your pain: □ the same □ worse □ improving

Prior to this collision, have you ever had any physical complaints similar to what you have now? No__ Yes__
If Yes, Explain:_____

FAMILY MEDICAL HISTORY:

Did your mother or father have any of the following? M= Mother; F= Father; B= Both

□ High Blood Pressure	□ Asthma	□ Stroke	□Arthritis
□ Heart Attack	□ Diabetes	□ Emphysema	□Kidney Disease
□ Cancer	□ Mental Illness	□ Pacemaker	□ Seizures
□ HIV Positive	□ Osteoporosis	□ Ulcer/Gastrointestinal Problems	

Other:_____

MEDICAL HISTORY:

CHECK ALL conditions that apply to YOU:

□Osteoarthritis	□Circulatory Problems	□Osteoporosis	□Depression
□Rheumatoid Arthritis	□HIV/AIDS	□Broken Bones	□Mental Illness
□Diabetes	□Stroke	□Cancer/Tumors	□Drug Addiction
□Hypertension	□Heart Attack	□Digestive problems	□Seizures
□Heart Disease	□Lungs/Asthma	□Kidney problems	□Alcoholism

□ Other:_____

Any history of Surgeries/Hospitalizations? No_____ Yes_____
If Yes, give date(s) and condition:_____
_____

Are you currently taking any medications? (other than pain meds for this accident) Yes_____ No_____
If Yes what kind?_____
_____

Have you been involved in any type of accident before? No_____ Yes_____
If yes, when?_____

•**FEMALES ONLY**: Are you currently pregnant? No____ Yes____ Date of last menses:_____
Is there any possibility that you could be pregnant? No_____ Yes_____ Don't Know_____

AUTO INSURANCE INFORMATION:

Name of Auto Insurance?_____ Policy Number:_____
Address:_____
Adjuster Name:_____ Phone Number:_____
Do you have PIP? No:___ Yes:___ Don't know:___ Claim Number:_____
Attorney's Name:_____ Phone Number:_____
Attorney's Address:_____

Third Party/Liable Information: Unknown_____ Insurance Carrier:_____
Was a police officer at the scene? Yes:___ No:___ If yes, was a report filed? Yes:___ No:___
Officer's Phone Number:_____

RELEASE OF INFORMATION

The above information is correct to the best of my knowledge. I understand that my information will be held in the strictest of confidence. It is my responsibility to notify this office of any changes and I will not hold my doctor or any members of his/her staff responsible for errors or omissions that I have made in completion of this form.

I authorize PAIN & REHAB CENTER, LLC and any of it subsidiaries to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges incurred at this office.

_____ _____
Patient Signature Date

_____
Parent/Guardian Signature